

# APPLICATION FOR SUBSIDY BY SPECIAL AUTHORITY

**APPLICANT** (stamp or sticker acceptable)      **PATIENT NHI:** .....      **REFERRER Reg No:** .....

Reg No: .....      First Names: .....      First Names: .....

Name: .....      Surname: .....      Surname: .....

Address: .....      DOB: .....      Address: .....

.....      Address: .....      .....

.....      .....

Fax Number: .....      Fax Number: .....

## Pravastatin

### INITIAL APPLICATION - Confirmed HIV/AIDS

Applications only from a named specialist. Approvals valid without further renewal unless notified.

#### Prerequisites (tick boxes where appropriate)

Patient has dyslipidaemia and an absolute 5 year cardiovascular risk of 15% or greater

and

Confirmed HIV infection

and

Patient is being treated with an HIV protease inhibitor

I confirm the above details are correct and that in signing this form I understand I may be audited.

Signed: ..... Date: .....

**Post application to Ministry of Health, Private Bag 3015, Wanganui – Fax: 0800 100 131**